PLAN OF CARE / COST COMPARISON BUDGET FOR THE MEDICALLY FRAGILE CHILDREN WAIVER

State Form 46019 (R4 / 11-98) HCBS 1C / 2C
Approved by State Board of Accounts, 1998

PLEASE FILL FORM OUT COMPLETELY.

CENTRAL OFFICE USE ONLY		
OMPP	Date	Initials
MWU	Date	Initials
Retuned	Date	Initials

This state agency is requesting disclousure of your Social Security number in order to expedite processing of your Plan of Care. Disclosure is voluntary and you will not be penalized for failure to disclose SSN per IC -4-1-8.

☐ Initial Plan of Care ☐ Re-Entry - Previous Termination Date _____ ☐ Update Plan of Care ☐ Annual Plan of Care

Last name	First name	Middle initial
Address *(number, street)*		
City, state, ZIP code		Date of birth
Medicaid number		Medicaid eligibility date
Social Security number		Area agency on aging number

Level of care *(please check one)*	Level of care - current approval date	Level of care - previous approval date
☐ J ☐ X ☐ Y ☐ Z	Date:	Date:
Diagnosis 1	Diagnosis 2	S.B. 30 Provision (*please check*) ☐ Yes ☐ No

START DATE WAIVER EFFECTIVE DATE:		**NURSING / HOS. FACILITY DISCHARGE DATE:**	

Recommendation

Plan of care - effective from to

A. HOME AND COMMUNITY - BASED CARE COSTS

1. Plan of care information:

a. Case management _____ (1/4 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____

b. Attendant Care _____ (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____

c. Respite Care / Attendant _____ (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____

/ Home Health Aide _____ (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____

/ LPN _____ (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____

/ RN _____ (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____

/ IDDARS - ILS _____ (1/2 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____

/ Other _____ (1 hr.) Units auth. / mo. _____ x Unit cost $ _____ = Mo. cost $ _____

d. Environmental Mod. 1 *(describe)* _____ Unit cost $ _____ = Mo. cost $ _____

Environmental Mod. 2 *(describe)* _____ Unit cost $ _____ = Mo. cost $ _____

Case Management Agency	**Total A.1 -** Waiver Service Costs	$
Case Manager I.D. Number (4 digits)	**Total A.2 -** Other Medicaid Cost	$
Case Manager Authorization Number (9 digits)	**Total A.5 -** HCBS Cost	$
	Total B.3 - Facility Cost	$

Date budget was completed

2. OTHER MEDICAID SERVICES

a. Physician _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

b. Pharmacy _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

c. Therapy _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

d. Lab / X - ray _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

e. Supplies _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

f. Durable medical equipment _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

g. Transportation _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

h. Private duty nursing _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

i. Home health aide _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

j. Other: _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

k. Other: _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

l. Other: _____ 3 mo. payment history $ _____ ÷ 3 = Estimated mo. cost _____

			Total A.2 - Other Medicaid Cost **$**
3. Total of lines	**A.1** $	**A.2** $	= $ **A.3**
4. Minus Recipient Spend-Down Amount			- $ **A.4**
5. Total Home and Community Care Costs			**= $** **A.5**

B. INSTITUTIONAL COSTS

1. Nursing facility institutional costs $ _____ **x 30 days**

or

Hospital institutional costs $ _____ **x 30 days** = $_____ **B.1**

2. Minus recipient liability reduction - $_____ **B.2**

3. Total institutional cost = $_____ **B.3**

C. DOCUMENTATION OF PAYMENT HISTORY - Indicate source(s) and dates of information used to determine cost reported in section A.2.

D. NON-REIMBURSED CAREGIVER

Type	Provider - specify name and address	Telephone number	Frequency
PRIMARY CAREGIVER	Name Address		**NA**

E. DESCRIPTION

Please describe how the Plan of Care provides adequate coverage to ensure the health and welfare of the waiver recipient. For Update Plan of Care, explain reasons(s) for the change(s).

F. COST COMPARISON DETERMINATION

1. Cost Comparison Data indicates:

a. If line **A.5** $ _____ is **LESS THAN** line **B.3** $ _____ , then the recipient is **ELIGIBLE** for Home and Community-Based Waiver Services and must be offered the choice of Nursing Facility / Hospital Institutional Care or Home and Community-Based Services.

☐ Recipient is **ELIGIBLE** for Home and Community-Based Waiver Services.

b. If line **A.5** $ _____ is **GREATER THAN** line **B.3** $ _____ , then the recipient **MAY NOT BE ELIGIBLE** for Home and Community-Based Waiver Services.

☐ Recipient **MAY NOT BE ELIGIBLE** for Home and Community-Based Waiver Services.

2. Request for Approval to Exceed Calculations

a. Monthly amount which exceeds institutional cost factor: $ _____

b. Duration of excess costs: _____

3. State Agency Determination to Exceed Cost

☐ Approved ☐ Denied

Authorized signature of waiver unit	Date signed (*month, day, year*)

G. FREEDOM OF CHOICE

A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver. I have been fully informed of the services available to me in a Nursing Facility / Hospital institutional settting. I understand the alternatives available and have been given the opportunity to choose between waiver services and institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services and institutional care.

1. Choice of Waiver Services:

☐ At this time, I have chosen to receive waiver services in a home and community-based setting, rather than in an institutional setting.

Signature of Recipient / Guardian	Date

2. Choice of Institutional Services:

☐ At this time, I have chosen to receive services in an institutional setting, rather than in a home and community-based setting.

Signature of Recipient / Guardian	Date

H. CHOICE OF PROVIDERS

If the receipient chooses to receive waiver services, they have the right to select any approved waiver service provider(s).

☐ I have been informed of my right ot choose any certified waiver service provider when selecting waiver service providers.

Signature of Recipient / Guardian	Date

I. EMERGENCY BACKUP PLANS

Describe how medical needs, supervision, behavior issues, etc., will be covered during an emergency.

J. NOTES

Include documentation of any unmet needs.

K. SIGNATURES

Signature of Case Manager	Case Manager's I.D. number	Date

L. STATE AGENCY PLAN OF CARE DETERMINATION

☐ Approved ☐ Disapproved	Signature of Authorized Waiver Unit Representative	Date